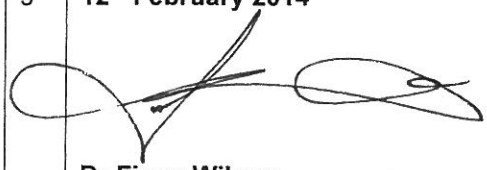
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Clinical Director,** **Harmoni HS,** **1st Floor,** **125, Upper Richmond Road,** **Putney,** **London.** **SW 15 2TL**
1	**CORONER** I am Dr Fiona Wilcox senior coroner for the coroner area of Inner West London.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 12th June 2013 I commenced an investigation into the death of Refat Hussain aged 25 years. The investigation concluded at the end of the inquest on 17th December 2013. The conclusion of the inquest was **Medical Cause of death:** ***1a Multi-organ failure.*** ***b In hospital cardiac arrest*** ***c Pulmonary Tuberculosis and pneumonia*** ***II Rubenstein Taybi Syndrome.*** **Conclusion of the Coroner as to the Death:** ***On 15/4/2013 Ms Refat Hussain was admitted to St Georges Hospital. She was initially diagnosed with bilateral community acquired pneumonia, was treated and improved a little. However, she developed haemoptysis on 21/4/2013 and suffered a cardiac arrest on 22/4/2013. She was confirmed the same day as suffering form pulmonary TB. Despite all active treatment she deteriorated and died on ITU on 11/5/2013. She had developed active signs of TB in February 2013. If she had been diagnosed and treated appropriately at that time then on the balance of probabilities the death would have been averted.***
4	**CIRCUMSTANCES OF THE DEATH** *Ms Hussain was part of an extended family most of whom developed either open TB or latent TB at the material time. Refat herself had been diagnosed with latent TB but had*

	not received treatment for this. In the early of February 2013, she had developed symptoms consistent with active TB, which for various reasons went unrecognised. *On 30th March 2013, she was visited at home by a Harmoni [redacted] who based upon the history given at the time and the examination of Ms Hussain, diagnosed a chest infection and prescribed antibiotics.* *[redacted] had no access to Ms Hussain's usual GP records, nor that of her family members which may have assisted him to make the diagnosis of TB and arrange appropriate treatment. It is possible that had [redacted] had such background information this death may have been averted.* *Based upon the information available to him, [redacted] diagnosis and treatment was reasonable and appropriate. This situation was further complicated as Ms Hussain was unable to give a clear history herself due to her Rubenstein Taybi syndrome.*
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) The lack of access to the patients GP medical records reduces the ability of out of hours GPs working for Harmoni to make accurate diagnoses.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th April 2014. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons 1. [redacted] 2. [redacted] The Heritage Medical Practice, 119 Northcote Road, Battersea, London. SW11 6PW. 3, [redacted]

	Consultant Medical Microbiologist, St Georges Hospital, Blackshaw Road, London. SW17 I have also sent it to : **The Care Quality Commission** who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**12th February 2014**  **Dr Fiona Wilcox,** **HM Senior Coroner Inner West London,** **The Coroner's Court,** **65 Horseferry Road,** **London.** **SW1P 2ED.**